BACKFLOW PREVENTION DEVICE TEST REPORT

Town of Smithfield

Name of Premises _____

Service Address _____

Use & Location of Device _____

Device _____ _____ _____ _____

Manufacturer | Model | Size | Serial No.

Line Pressure at Time of Test _____ psi Existing/Replacement/New Device (circle one)

REDUCED PRESSURE DEVICE	REQUIREMENT	INITIAL TEST	REPAIRS	RETEST
Check Valve #1	Closed tight? minimum of 5.0 psid	yes/no (circle one) _____psid		yes/no _____psid
Check Valve #2	Closed tight?	yes/no (circle one)		yes/no
Differential Pressure Relief Port	Must open at min. of 2.0 psid	Opened at _____psid		Opened at _____psid
DOUBLE CHECK VALVE DEVICE	**REQUIRMENT**	**INITIAL TEST**	**REPAIRS**	**RETEST**
Check Valve #1	Closed tight at a minimum of 1.0 psid?	yes/no (circle one) _____psid		yes/no _____psid
Check Valve #2	Closed tight at a minimum of 1.0 psid?	yes/no (circle one) _____psid		yes/no _____psid
PRESSURE VACUUM BREAKER	**REQUIRMENT**	**INITIAL TEST**	**REPAIRS**	**RETEST**
Air Inlet	Opened at min. of 1.0 psid?	yes/no (circle one) _____psid		yes/no _____psid
Check Valve	Closed tight at a minimum of 1.0 psid?	yes/no (circle one) _____psid		yes/no _____psid

Remarks _____

Certification: I have made the above test and hereby certify that this backflow prevention device performed satisfactory and meets all federal, state and local codes and regulations as required.

Tester Name _____ Date _____

License #_____ Expiration Date _____ City of Certification _____

Testing Company _____ Phone # _____

Company Address _____

Mail forms to Will Councill at 310 Institute Street, Smithfield, VA 23430.